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ABSTRACT

Case studies of three children who participated in the play program at Auckland Hospital in New Zealand are presented. About a third of the children admitted to the hospital have access to the play program, but only a few are able to participate in individual sessions with a hospital play specialist. The first case study described in this report is that of a 3-year-old child who required only minor surgery, but who associated hospitals with death, separation, and acute illness due to experiences of several family members. His avoidant behavior was overcome by means of play on medical themes and the involvement of other members of his family. The second case is that of a 6-year-old developmentally delayed boy whose emergency surgery resulted in an extended stay with postsurgical complications. His unexpected admission, and the frightening circumstances surrounding it, caused him to withdraw and revert to babyish behavior. But 11 sessions of play therapy using role-playing enabled him to progress. The third case study is that of a 4-year-old boy who had congenital problems requiring repeated corrective surgery and who was fearful of hospitals and refused to be examined by a physician. His free play represented symbolic themes common in the play of hospitalized preschoolers, including helplessness, powerlessness, separation, and lack of control or autonomy. Contains 18 references. (LB)

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Making Sense of it: The role of play in assisting children requiring extensive hospitalization to understand and cope with their illness, its treatment and their hospital experience.

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Walk into any children's ward in New Zealand and it is immediately apparent that the child's surroundings and experiences are very different from that of a child in his or her home. The hospital environment is an alien one, where children's familiar routines are interrupted, and where they are surrounded with strange - and often frightening - people, equipment, sounds and smells. Newly acquired skills and behaviours may be interfered with, and opportunities for play and exploration are severely curtailed or non-existent. Toddlers may be kept in their cots for long periods because their physical safety cannot otherwise be assured. Children are subjected to a number of new experiences, at least some of which are likely to be invasive and painful. They may be separated from the people who are familiar and important to them. Loved and trusted adults may refuse to give them anything to eat or drink and or may permit strangers to perform procedures which the child experiences as distressing. They may even forcibly restrain the child for these procedures. Children may be in isolation, shut in individual rooms without toys or stimulation, or, conversely, they may be overwhelmed with noise and activity. They will overhear numerous conversations, which may or may not be related to them, and will see other children in various states of distress, often without knowing the reason for their distress. They will witness a number of treatment procedures - IV insertion, nasogastric tubes, plaster casts - and may have no way of knowing whether the treatments that they see are planned for them.

There is now ample research to demonstrate that hospitalization has considerable potential to cause long-lasting emotional damage. (Vernon, 1966; Douglas, 1975; Quinton & Rutter, 1976; Golden, 1983; Thompson, 1986) We know that the experience of being in hospital is, of itself, a major stress for children which is additional to the stress of the illness. Children respond to this stress in various ways, according to their age, their personality and emotional state, their previous experience of hospitals and separation; the nature of their illness and treatment; the environment they experience in hospital; and the attitude of those caring for them. (Barker, 1974; Beuf, 1979; Simons, Bradshaw & Silva, 1980; Thompson and Stanford, 1981). It is not surprising that developmental regression is common, and that emotional withdrawal may be adopted as a way of shutting out experiences with which the child is ill-equipped to cope. (Gibbons, Martha, Blechar, 1985; Thompson & Stanford, 1981, pp.18-22; Thompson, 1986)

We also know what we need to do to assist children to maintain their normal development and their emotional wellbeing while in hospital. We know that we can make changes in the environment and in the way we structure the experience of being in hospital so that it can become a positive experience for the child and for the family. There is no doubt that, for the young child, the most important thing we can do is to make sure that the child has the support of someone important to them (usually a parent or another family member). If a familiar person cannot stay with the child, then the child needs a "substitute" caregiver who can provide continuity as far as possible.

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Next to the presence of a parent or familiar adult, most studies have identified access to play activities as the most significant intervention. Play is an integral part of a child's life. It may often be pleasurable, but it is not frivolous. In a strange environment such as hospital, play has a "normalizing" effect. It is the natural medium of experience and conflict resolution for children and can mediate between the child and experiences which might otherwise overwhelm them. In hospital, play becomes a "lifeline" to the familiar world of home, family and familiar activities. Play is something that children know how to do, and know how to do well. We know that the provision of therapeutic play programmes provided by trained staff makes a difference to children's anxiety levels and to their understanding of illness and treatment. (Clatworthy, 1982; Thompson, 1988; Wolfer et al, 1988)

The case studies that follow illustrate the experiences of three children who have participated in the play programme at Auckland Hospital. The aims and theoretical and conceptual framework of this programme are described in some detail elsewhere. (Matthews, 1991) By a coincidence, all three are boys who have been admitted for surgical procedures. There is nothing particularly unusual about their circumstances and there is certainly nothing unique about the way in which they have used play to cope with their anxieties associated with their hospitalization and treatment. Current staffing levels mean that only about one third of the children admitted have access to the play programme, and only a very few are able to participate in individual sessions with a hospital Play Specialist to prepare them, through play, for anticipated procedures. We do not have sufficient staff to work with children having surgery on a day-stay basis or children receiving treatment or tests as outpatients, although we endeavour to do so if we receive a referral.

Case Study (Day Stay surgery):

Timothy (3 years) required minor surgery as a day stay patient. However, a grandparent had recently died in hospital and his Mum had been to hospital for the birth of a baby sister. During this time, his sister had had an emergency admission and Timothy stayed in hospital with his hospitalized sister, a well sister and his father. His parents reported that Timothy had refused to be examined at outpatients' clinic and was talking about hospitals as places where people died. They said he was so frightened of hospital that they could not persuade him to enter the building. They phoned to ask for help in overcoming Timothy's anxiety before admission.

Arrangements were made for Timothy and his family (including his sisters) to come to the hospital playroom (which he could do without walking through the building) "just to play" 3 days before his booked admission. Timothy's parents had read him a book about hospitals, but the storybook child's admission and treatment were very different from Timothy's situation. When Timothy arrived in the playroom he immediately wanted to see the toy castle and soldiers which were in the storybook playroom! He was enthusiastic at the suggestion that he and I make a cardboard castle together. However, Timothy would not participate in medical play or take any part when I played through the anaesthetic procedure on a calico doll. He was happy to try the anaesthetic mask on his father, but would not wear it, or the hats and mask, himself.

While the paint on his castle was drying, Timothy came very happily with me (his parents following) to the ward where he would be, and I pointed out the things that were most like home - the playroom, his bed, the kitchen, bathroom, etc. His parents expressed a wish to be with him while anaesthesia was induced and I suggested they talk to the charge nurse to ensure that this was arranged. We also visited the ward where Timothy's sister had been. Timothy's sister was able to say hi to the nurses who had looked after her and give them a thankyou card she'd made.

On the morning of Timothy's admission I met them in the ward playroom. Timothy took me to his bed to show me the castle, leaving his parents in the playroom. We played through the theatre procedure with the hospital Playmobil set. When the little boy figure got to the operating room Timothy turned away from the play and began playing with the toy railway. We made a circle of the track, and a siding which headed towards the hospital. I dressed in the theatre hat and mask and pretended to be the doctor waiting for the little boy to come to hospital. Timothy accepted the suggestion that the little boy might come on the train and he put the small figure in a carriage. However, he took the train round and round the track, not up the siding towards the hospital! We played a game of the doctor listening for the train - hearing it get closer and closer, then hearing it going away. Eventually Timothy was able to bring the train to the hospital. We told the train to wait right outside, ready to take the little boy home again. Timothy was still reluctant to participate in playing through the anaesthetic, but watched again while his father held the doll and I role-played the doctor giving the dolly his special sleep medicine while dolly had his operation, and then waking him up again.

Post-op I played briefly again in the playroom with Timothy before he was discharged. He was confident and happy, and his parents reported that all had gone well.

Timothy's age, and his previous association of hospitals with death, with acute illness, with separation from his mother and with the arrival of a new baby, made him particularly vulnerable to the potential ill effects of hospitalization. For his family, too, their recent experience of hospitals had been of sadness, stress, anxiety and separation. Wisely, his parents recognised his vulnerability. Timothy's anxiety evidenced itself as avoidant behaviour - his inability to involve himself directly in medical play or preparation, and in his initial inability to take the little boy figure to hospital. By enabling him to approach the experience in gradual stages it became a positive one for the whole family. Timothy was able to learn that there were many things in hospital which were much like home - that his family would be with him and that there were fun things to do. Given sufficient time, he was able to regain some control over what would happen, to clarify in what way his surgery would be different from what had happened in hospital in his previous experience, and to familiarise himself with the sequence of events. We were also able to identify that the anaesthesia mask was likely to be very distressing, and so to ensure that his father was with him to support him during induction. His sisters, too, had the opportunity to participate in medical play, to widen their understanding of hospitals, and to learn about and share in Timothy's experience.

Case Study (Extended stay with post-surgical complications):

Tommy (6 years) is developmentally delayed. He had commenced school on his 6th birthday with support from a teacher aide. Only about three weeks after commencing school he required emergency surgery. Complications developed which required his admission to an adult Intensive Care unit, where he stayed for two weeks. Tommy had had no preparation before admission, nor had he had any play activities post-op. English was his second language. When I first made contact he was lying very still, silent and wide-eyed. However, at the mention of "playdough" his hand shot out to grab it, but he made no attempt to use it other than to hold and squeeze.

Between play sessions Tommy continued to spend much of his time lying still and silent in bed. By the fourth session, however, he seemed happy to have his bed raised so he could play with dried beans, cars and trucks, and containers for pouring. Concerns had been expressed about his regression, both in play and in behaviour (he was bedwetting, which was not thought to be a result of the surgery). Tommy spoke occasionally, but too quietly for me to pick what he was saying. His play was at the level of a toddler - filling and emptying the various containers, shaking them, and banging them together. His expression was sombre and intent.

Other staff were expressing concern that Tommy had been avoiding contact, turning his head away, telling them to go away, and seemed very withdrawn. The nurses said they were having difficulty in persuading him even to sit up in bed other than for very brief periods. The schoolteacher mentioned that he had been very distressed on the previous day when his drip was reinserted.

At the next play session I brought an assortment of real and play medical equipment, plus a wistful looking dog puppet ("Pup"). Tommy drew my attention to the IV in his hand. I said I guessed it had hurt, to which he nodded. I introduced the Pup to Tommy's gorilla and suggested that maybe gorilla would like to try out some of the doctor things. Tommy smiled when Pup found it hard to sit still. Gorilla tried on the surgical hat and mask and Tommy again drew attention to his drip. I asked Tommy if maybe Pup would need a drip too. Tommy thought he would, and watched intently as I inserted it. Tommy would not wear the theatre hat, mask or gloves, nor would he help with insertion of the drip, but he did respond to my request for help in choosing which of Pup's hands to use, and in helping with cleaning and taping.

Tommy asked what other doctor things I had. He explored the bag, finding the ecg buttons and sticking them on Pup's chest. I said maybe Pup had a sore tummy and would need an operation to fix it, like Tommy, to which he nodded agreement. We then played through the operation. At this point Tommy became very involved and active in the play, directing how Pup would have his anaesthetic (through his IV), showing me correctly with a biro where the opening would be to fix Pup's tummy and covered it with a dressing. I said maybe Pup's operation was all over and it was time to wake him up. Tommy hesitated,

then asked for another dressing which he placed over the first. He put the mask on Pup and shook him gently - "Wake up Pup, wake up Pup". He removed the mask, leaving the ecg buttons. He then played for a long time with the drip, making it faster and slower. As water soaked into Pup it began to drip out around the bottom of the puppet. Tommy pointed this out and I reassured him that it didn't matter. He laughed at the suggestion that it looked like Pup was wetting the bed.

During the doctors' rounds Tommy became quiet and tense, clenching his drip hand very tightly on the bed. When they'd gone, I pretended to talk for Pup and Tommy made Pup move. He took over the speaking for Pup, saying "I don't like the drip, I don't like the drip." I said I guessed Pup hoped it would be taken out soon, and Tommy moved Pup's head up and down for "yes". I suggested that maybe it would be taken out when Pup was drinking and eating well again and getting better. Tommy said it was time for Pup's drip to come out. He held the cotton wool and sticky tape while I removed the drip, and after a little more play he started to take the dressings off. I commented that it seemed like Pup was getting better and was nearly ready to go home. Tommy agreed he was. At this point visitors arrived, Tommy greeted them enthusiastically and suddenly got up, swung his legs over the bed and tried to walk unaided to a nearby chair. Tommy and the visiting child laughed when Pup waved goodbye to gorilla and I took him "home".

In every following play session, Tommy repeated the operation and Pup getting better, each time adding a little bit more to the game. Each time Pup got well and went home, and each play session was followed by increased physical activity on Tommy's part.

In the ninth play session, Tommy played through the surgery, but left the IV lure in Pup's "arm". At the ward meeting, staff had expressed continuing concern about his reluctance to eat or drink, what they perceived as his lack of concentration, and his unwillingness to do any school work.

At the next session Tommy commented that Pup still had his drip. "Pup won't eat", Tommy said solemnly. He had had a blood test that morning and repeated this on a calico doll. Tommy wouldn't draw a face on the doll, so I drew a sad one with tears. Tommy said the "ows" very loudly for the doll.

By the eleventh play session, Tommy had become very assertive - requesting specific items of equipment. He again pretended to do a blood test, and insert an IV. When the IV was taken out Tommy said the doll would not need tears any more and asked me to draw a happy face on the reverse side. He again wanted to play operations, but by this time could list all the equipment needed. Tommy put the mask on Pup, and said for him, "Take it off. Take it off." His Mum commented that this is what Tommy had said in the operating room. Tommy drew a face on another calico doll - this doll was Pup's visitor. Again Pup got completely well. This time when Pup had recovered from the operation Tommy asked if Pup could run round and play with his friends. I said I was sure he could, so Tommy made Pup dance and cuddle the visitor doll. Tommy then called out across the room to the school teacher that he was ready to do some schoolwork. This play session absorbed him for an hour and a half and seemed to mark the end of his need to repeatedly play through the surgery.

Tommy's vulnerability related to the emergency nature of his unexpected admission, with no time for preparation, and the frightening circumstances of the early part of his hospital stay. In addition, his developmental delay and poor language skills increased the likelihood that he would have misconceptions and anxieties that he might have difficulty expressing. Tommy responded to the stress of what was happening by withdrawing, and by reverting to more babyish behaviour. Very withdrawn children, who may seem to be too unwell to play, often respond surprisingly quickly, as did Tommy, to familiar play activities. In working with Tommy, play became a "bridge" to form a relationship of trust with the Hospital Play Specialist. Playing "for" Tommy in the early stages and reflective listening techniques acknowledged to Tommy that his feelings of distress were acceptable and to be expected. Role playing his experience, using toys, enabled him to proceed at his own pace in approaching aspects of his experience which were distressing. Through play he was able to reassure himself that he would indeed get better, resume his friendships and former activities, and - most importantly - go home. (For a comprehensive guide to playing with children in hospital, see Petrillo and Sanger, 1980.)

Case Study (Congenital problems requiring repeated corrective surgery):

Stephen (4 years) has had two operations on his feet and other operations on his ears. He has spent time in plaster following foot surgery and again following a broken leg. He walks on the sides of his feet and they give him considerable pain. He requires corrective surgery which will involve inserting metal pins and rings into his lower legs and feet. These pins will remain for 3-4 months, and then he will be in plaster for 6-8 weeks.

Stephen was referred to the Hospital Play Specialists by his orthopaedic surgeon because of his fear of doctors and hospitals, and his refusal to be examined. His surgeon did not consider that the surgery could proceed until Stephen was emotionally able to cope.

At his first visit to the playroom Stephen initially clung to his Mum. He responded to a request to help me find some things to play with and became involved in setting out the train track. From time to time he glanced at various items in the medical play corner, and as he did so I named the pieces of equipment in a matter of fact manner and briefly said why they were used. He didn't approach or ask any questions. His train crashed off the track. I wondered if there were any people on the train - maybe they were hurt and would need to go to hospital. Stephen made a playdough person and put him in the hospital bed. He was then easily encouraged to play with the hospital playmobil, and commenced to explore the medical play equipment. He found the rubber anaesthesia mask and wanted to take it home for his monkey. I suggested he take the plastic one instead, and some operating theatre hats and masks for him and his sister. At first he refused these, but then changed his mind and took a hat and mask. He asked if he could come again to play with the train and the hospital things.

At the next visit, two weeks later, Stephen's mum commented that he had played a lot at home with the theatre things. Stephen came down the path to the playroom as quickly as he was able. He became engrossed with water play with syringes and tubing, and with the IV equipment. He asked for the hospital people (the Playmobil Hospital set) and asked a lot of questions about the uses of the various pieces of miniature equipment and furniture, and where they should go in the toy hospital. He made playdough people for the hospital and a playdough monster "to scare the people in the hospital". Suddenly he switched his attention to the sand. He repeatedly buried the toy cars and motorbikes, pretending to "rev up" their engines to get them out.

Stephen chose to paint at the start of the next session - one of his paintings was of a blue snake-like monster. When he tired of this I suggested he might like to play with the plaster bandage. He drew a face on the calico doll. His mum asked if dolly had a happy face. I said maybe dolly was a bit worried about getting plaster on his feet. Stephen said very definitely, "No, he's angry". I said maybe he thinks it's just not fair, and Stephen nodded. He plastered both of the doll's feet with several layers of plaster bandage, then immediately tried to remove the plaster by cutting it off with scissors. I reminded him to tell dolly that the plaster had to stay on for a long time while Dolly's feet healed. Stephen took the doll home, still with the plaster.

I had the toy medical kit out on the table when Stephen arrived for the fourth session, and also had "Pup" (the sad-eyed dog puppet) on the table dressed in the doctor's hat and stethoscope. Stephen commented on Pup's sad face and I said maybe he was wondering what was going to happen. Stephen took Pup's blood pressure, listened with the stethoscope, and generally played through the routine checks, temperature taking etc. (These were all procedures with which Stephen had refused to comply.) Stephen picked up the anaesthesia mask, holding it to Pup's face first, and then his own. He responded happily to the suggestion that Pup would need some special medicine through the mask while Dr Stephen fixed his feet. Stephen dressed in the theatre hat and mask to do the "operation", insisting on doing it all "by myself". He then asked to repeat it on the doll. He drew a face on the doll, who was again angry. He played through the anaesthesia procedure, then proceeded to give the doll lots of pink medicine. This spilt down the doll's tummy and Stephen commented that it looked like blood. Dolly needed lots of injections, for which I was asked to say increasingly loud "ouches". He wanted to take the miniature "machines" home, but his Mum suggested they could make some together. He also asked for a medical kit and stethoscope. For the remainder of the session he played with two toy ambulances, putting people on stretchers. At one stage he commented that the little person was dead. Near the end of the session he asked if it was time to go. He said he didn't want to go, but nevertheless left quite happily, asking for the ambulances and Pup for next time. This was the first session spent entirely in medical play.

I had fingerpaint ready at the start of the fifth session. Stephen was a little reluctant to touch it at first, then became deeply engrossed in making swirly patterns and, later, an angry face. He made a "gooby monster" out of the fingerpaint. We played at guessing what would make the gooby monster go away, then Stephen's fingerpaint-covered hands became the monster and I pretended to be scared. He took the wooden people off the playroom shelf and played that they were stuck in the fingerpaint. All the figures were

dying or dead. He smeared fingerpaint all over them, and then put them in a bowl of warm water. They were all drowning except for the little boy figure. He incorporated a miniature swimming pool in the play - sometimes the figures would float with a toy lifejacket, sometimes they couldn't have the lifejacket and were drowning. He chose various vehicles to come to the rescue of the people. None of these were any good at rescuing. I suggested he could try the ambulances, and he accepted this, using the stretcher to rescue some of the figures. His play had an intense, absorbed quality not seen to the same extent in earlier sessions. When it was time to go he seemed very reluctant to leave, hiding his face sadly in his mum's skirt.

A few days following this visit, Stephen had an appointment with his surgeon. He chatted to the doctor, telling him about what he'd been doing in his play sessions, and got off his mum's knee happily to lie on the examination table while the doctor examined him and checked his feet.

Next session Stephen told me that he'd been to see his doctor and "I didn't cry". He again played with fingerpaint and with putting little figures in the bowl of water. However, this time he chose "super hero" plastic figures, and all of them could swim. There was no further talk of drowning, or of the need for life jackets.

Many children, particularly those born with congenital problems, may require a number of hospital admissions and medical treatments each of which, individually, may seem to medical staff at the time to be relatively "minor" and of no particular significance. Without the opportunity to receive developmentally appropriate preparation and support, however, such children commonly become increasingly distressed and fearful about even the simplest procedures. The prospect of further surgery may understandably become very frightening for them.

Stephen's free play represented not only experiences he had actually had, but also showed several symbolic themes expressive of his experiences. Such themes are common in the play of preschoolers in hospital - themes of helplessness, powerlessness, separation, and lack of control or autonomy. (Oremland, 1988; Petrillo and Sanger, 1980) His angry feelings were acknowledged. With assistance from a Hospital Play Specialist he was able to take control over the monsters, and find more optimistic solutions when disasters overtook the people in his games.

In direct medical play, he was given an opportunity to become familiar with some of the procedures and treatments he had experienced. By playing at being the doctor, he was able to become an active, rather than a passive participant and so regain a sense of mastery.

Children have a right to information about their hospital admission and treatment. They need to have this explained to them in sensory terms, in terms of what they will see and feel and hear and taste. They need to know that they are not in hospital because they have been naughty, and they need help to understand that treatment is not a punishment but is to help them get better. They need to know which part of their body will be involved in any procedures or surgery, and that the rest of their body will not be touched. They need to know that nurses and doctors understand that they might be feeling scared, or anxious, or angry and that lots of other children (and grownups) feel like this too. They need to know that it is okay to cry. They need to know that they will go home again.

Young children do not, however, need a lot of detailed information about their illness. Children's understanding of illness is primarily determined by cognitive maturation. Logical concepts, such as cause of illness, necessity of treatment and the role of medical personnel are often beyond the developmental ability of the young child. Understanding becomes more complex as the child's cognitive processes mature and, therefore, for the chronically ill child, explanations must be repeated at various developmental levels as the child matures. (Brewster, 1982; Feldman & Varni, 1985). For the young child, such explanations can only be presented through play.

The event of hospitalization seriously threatens the quality of play and the extent to which the child may engage in it. To discourage or prevent play is to impede normal development. Hospitalization and illness are stressful enough for children; we should not be doing further harm by our failure to provide for their ongoing developmental and emotional needs. There is no doubt that children in hospital, if provided with the facilities to play and sufficient support from a skilled adult, will use play to maintain normal development, to increase understanding, and as a vehicle for self-expression and retention of a sense of mastery and control.

The question must be asked as to what emotional legacy is left for the hundreds of New Zealand children who have experiences similar to those of Timothy, Tommy and Stephen but who do not have an opportunity to work through these experiences in play?

Hospitals cannot claim to provide quality paediatric healthcare (or even adequate care) unless they are providing appropriate play programmes to which all children have access. No hospital programme can be effective without appropriately trained adults skilled in assisting the child to express fears and obtain resolution of these, in using play as a tool for enhanced communication, and in preparing children through play for medical procedures. For children to derive optimum benefit from hospital play programmes, all staff caring for children need an understanding of children's developmental needs and, in particular, the role of play as a therapeutic medium. (Thompson and Stanford, 1981)

Sadly, the provision of play programmes in New Zealand hospitals has not been seen as a priority in paediatric care. The situation has changed little since Robin McKinlay's address to the Third Early New Zealand Early Childhood Conference in 1983. (McKinlay, 1983) At that stage she recommended "tact and caution" in the introduction of changes. Nearly ten years later, the time is overdue to throw caution to the winds (though perhaps not tact!). We know what is needed. We know how to implement appropriate programmes. It's time we did so.

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